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**AN INTERVIEW WITH THREE DEAF LESBIANS: INTERSECTIONALITY
AND SALIENCY OF IDENTITY VARIABLES**

PROFESSIONAL DISSERTATION SUBMITTED TO THE FACULTY

OF

**THE SCHOOL OF PROFESSIONAL PSYCHOLOGY
WRIGHT STATE UNIVERSITY**

BY

AMANDA L. SCHAAD, Psy.M.

**IN PARTIAL FULFILLMENT OF THE
REQUIREMENTS FOR THE DEGREE
OF
DOCTOR OF PSYCHOLOGY**

Dayton, Ohio

July, 2016

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WRIGHT STATE UNIVERSITY
SCHOOL OF PROFESSIONAL PSYCHOLOGY

July 2, 2015

I HEREBY RECOMMEND THAT THE DISSERTATION PREPARED UNDER MY SUPERVISION BY **AMANDA SCHAAD** ENTITLED **AN INTERVIEW WITH THREE DEAF LESBIANS: INTERSECTIONALITY AND SALIENCY OF IDENTITY VARIABLES** BE ACCEPTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF DOCTOR OF PSYCHOLOGY.

Julie Williams, Psy.D., ABPP (RP)
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Abstract

LGBQ and Deaf communities have experienced parallel histories of oppression, medicalization, and discrimination that results in poor access to sexual health information and support around sexuality. Moreover, when the two identities intersect the impacts are magnified. Both populations experience vulnerabilities to sexual abuse, and inadequate sexual health information and /or sex education, compared to the majority population. Therefore, there needs to be a better understanding of their experiences with sex education and how mental health services could be helpful, particularly when these identities intersect. The aim and purpose of this study was to explore the interaction between LGBQ (Lesbian, Gay, Bisexual & Queer) and Deaf community identity. Specifically, to interpret the level of integration of both identities within each perspective community (LGBQ and Deaf) and to investigate sex education related issues in both populations. Three hypotheses were formed which were: there is a lack of inclusive sex education, identification with one community will be more salient than the other, and there is more reported experiences of discrimination within this subpopulation. Sixteen questions were developed with the input of persons within the Deaf community and professionals who work within the Deaf community. A focus group was conducted with three Deaf lesbian women. Results indicated that the women experienced multiple layers of oppression from both the hearing world and heterosexuals. All women identified that deafness was their most salient identity variable. All participants reported a lack of inclusive sex education and a disengagement from the LGBTQ community. Themes reflecting internalized oppression related to sexual orientation were expressed. Further research with this subpopulation is needed to inform the needs of these individuals.

Specifically, more focus groups should be conducted with varying races, sexual orientations and ages so that results can be used to develop methods of assessment and/or interventions.

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I would like to dedicate this dissertation to my mother, who has always supported me, loved me and carried me through the toughest times. You are my rock. I appreciate you, and I could have never become the woman I am today without you.

To My Sunshine: “Be the change you want to see in the world” -Gandhi.

Chapter I: Statement of Problem

LGBQ and Deaf communities have experienced parallel histories of oppression, medicalization, and discrimination that results in poor access to sexual health information and support around sexuality (Horowitz & Newcomb, 2001; Klinger, 2007). Moreover, when the two identities intersect the impacts are magnified. Both populations experience vulnerabilities to sexual abuse, and inadequate sexual health information and /or sex education, compared to the majority population (Ard & Makadon, 2012; Klinger, 2007). Therefore, there is a need for better understanding of their experiences with sex education and how mental health services could be helpful, particularly when these identities intersect. The aim and purpose of this study was to explore the lived experiences and needs of LGBQ (Lesbian, Gay, Bisexual & Queer/Questioning) Deaf individuals within the Deaf community. Specifically, to interpret the level of integration of both identities within each perspective community, LGBQ and Deaf, and to investigate sex education related issues in the Deaf community as well as in the sexually diverse communities. To accomplish this goal a focus group was attempted and facilitated to gather qualitative information from LGBQ Deaf women. This begins to address a gap in which Deaf lesbians are largely neglected in the research (Ladd, 2003).

It is estimated that roughly 2-4 out of every 1,000 persons are deaf in the United States (GRI, 2005). Deaf persons tend to experience similar rates of mental health disorders as the hearing population (Critchfield, 2002). This author references many

studies that concluded that deaf persons experience higher rates of Axis II disorders and childhood behavioral problems. Whether this is due to misdiagnosis or actual rates is unknown. Research also indicates that deaf persons experience a much higher rate of physical and sexual abuse (Elder, 1993). As quoted in Klinger (2007), “Statistics show that compared to hearing people, there is a much higher sexual abuse rate among deaf children. In addition, the incidence rate of drug and alcohol abuse among the deaf population seems to be higher than in the hearing community. Taking these statistics into consideration, deaf individuals are placed at a higher risk of becoming infected with HIV” (p. 20). Kenny & Buchholz (1995) reported that reasons for the Deaf population’s vulnerability to HIV stem from their lack of information regarding sex, AIDS, prevention program accessibility, inadequate sex education, and high sexual assault rates.

Roughly 3.5% of the United States population identifies as lesbian, gay or bisexual (Ard & Makadon, 2012). In 1966 psychiatry labeled homosexuality as an official disorder which could be treated by, what is now seen as unethical practices, castration, electroshock therapy and conversion therapy (Horowitz & Newcomb, 2001; Ard & Makadon, 2012). Homosexuality, as a mental disorder, was not removed from the Diagnostic Statistical Manual until 1973. This discriminatory treatment still adversely affects the rates at which LGBQ members seek services within the health field (Ard & Makadon, 2012). Moreover, lower numbers of LGBQ seek services for fear of discrimination, insensitivity, general lack of knowledge about their sexual identity and feelings of worthiness and low self-esteem. This is particularly problematic given, as cited by Ard & Makadon (2012), that LGBQ members experience higher rates of substance abuse and mental disorders such as depression and anxiety. The authors go on

to explain that this is most likely due to “minority stress” which is the experience of prejudice (real or imagined) that LGBTQ persons face on a daily basis which then turns into internalized homophobia, including internalized self-loathing (Meyer, 2003). Cochran, Sullivan & Mays (2003) stated that LGBTQ persons are at least two and half times more likely to suffer from a mental health disorder than their heterosexual peers as a consequence of poor treatment or no treatment. There have been some inconsistent findings in the research with regards to use of mental health services within this population. Such as, Perez, DeBord & Biescke (2000) found that LGB persons use psychological services more frequently. Even though there are disagreements about the rate of use of services for this population, it is clear that they experience inadequate, exclusive, and insensitive treatment and are at a higher risk for mental disorders.

A focus group was completed within the Deaf community in order to gather qualitative data about the lived experiences of Deaf LGBTQ persons. Sixteen questions were developed consistent with participatory action research guidelines, in that members of the Deaf community and experts in the field were consulted in developing the questions and informing pertinent demographic information for the demographic questionnaire. Following the focus group, the researcher identified emergent themes generated from the transcripts and summaries of the participants’ responses. The initial intent was to complete three focus groups, with roughly eight participants in each. However, only one focus group was completed at the time of this study, given difficulty accessing this small population. With this in mind, generalizability is limited given geographic location and the size of the one focus group conducted. However, the study allowed for more research to be added to the literature about this population and the

results indicate a need for more research to be done within this community. Barriers to accessing this community will be discussed and strategies for future research will be offered.

The LGBTQ Deaf community remains an invisible community deserving of more attention, research and resources in regards to sexual education and mental health providers are in prime positions to promote and support sexual identity and health. The Deaf LGBTQ community experiences increased risks for sexual abuse, mental health issues, internalized oppression and multiple layers of discrimination due to the impact of being a double minority status. Future research is needed with attention to clinical intervention to address possible marginalization and discrimination experienced within each community.

Key Terms

deaf: the lower case “d” in this paper will refer to either the state of “deafness” or those whom do not identify as part of the Deaf community

Deaf: the upper case “D” in this paper will refer to those whom identify as part of the Deaf community or to reference Deaf culture.

LGBTQ: this term refers to Lesbian, Gay, Bisexual and Queer/Questioning. Transgender persons were not included for this study, as they have distinct and different experiences related to gender identity, not sexual orientation.

Chapter II: Literature Review

The purpose of this literature review is to inform the reader about the history of Deaf culture and how it applies to mental health, the Deaf & LGBTQ interaction, the history of sex education within the United States, and how all of these factors interact, leaving a population vulnerable to inadequate services. Additionally it will emphasize the importance of culturally inclusive sex education. The literature was pulled from *PsychInfo*, *Gender Studies Database*, *LGBT Life*, *PsychTests* and *Discover Layer* databases.

Deaf Community

Throughout this research it is important to understand terminology pertaining to Deaf culture. The term *Deaf culture*, was developed in the 1970s to distinguish the distinct community of Deaf persons whom share common values, common experiences, common language and a unique way of interacting with the world (Nomeland & Nomeland, 2012; Ladd, 2003). The capital “D” in “Deaf” refers to culture and community while lower-cased “d” in “deaf” refers to person whom have a condition of deafness or hearing loss (Padden & Humphries, 2005). In addition, hard of hearing persons or persons with some degree of loss of hearing, may or may not define themselves as part of Deaf culture. When a person acquires deafness later in life, they have not been raised in the Deaf culture, and may not define themselves as part of the Deaf community.

Most Deaf persons grow up hearing the story of Thomas Hopkins Gallaudet and Laurent Clerc, whom are accredited with starting a revolution (Edwards, 2012). In the early 1800's deaf children were either sent abroad to be taught or went without formal education and used "home-signs" or signs created for use within the family/peers for communication (Edwards, 2012). There were no schools for the deaf in the United States at this time. A man named Mason Cogswell began a campaign for implementing a school for the deaf in Connecticut after his daughter was diagnosed with meningitis and lost her hearing (Edwards, 2012). He ultimately raised enough money to send Thomas Hopkins Gallaudet, a friend of the family, to Europe in order to gather information on how to start and implement a school for the deaf in the United States (Edwards, 2012). In Europe, Gallaudet met a man named Duglad Stewart whom irrevocably convinced Gallaudet that the manual method (sing language) was the only way to truly teach deaf children (Edwards, 2012). At this time in history the manual method and the oral method were battling for the definition of the "correct" and best way to teach deaf individuals. Gallaudet stayed to study the French-manual method and ultimately enlisted Laurent Clerc to accompany him to the United States with the mission to start a school for the deaf. After much propaganda and campaigning in the United States, Hartford, Connecticut opened the American School for the Deaf in 1817 (Edwards, 2012). Deaf culture was born out of residential schools as a consequence of a sense of unity that formed around shared lived experiences. Deaf community transformed and spread throughout the United States and in 1864 Gallaudet College, now Gallaudet University was founded as an all Deaf college (Edwards, 2012). This is by no means a

comprehensive review of the history of Deaf culture, but serves the purpose of educating the reader on fundamental aspects of deaf education in the United States.

Deaf children tend to not be born into their culture since roughly 90% of deaf children are born to hearing parents (Padden & Humphries, 2005; Langholtz & Rendon, 1991; Klinger, 2007). This is problem given that communication is often difficult in the home with hearing parents, as most parents do not learn sign language and that deaf children are often isolated from other deaf persons. One solution to this problem was to develop schools specifically for deaf children which also addressed the need for better education than hearing schools were providing. During the 1900's up until roughly 1970 there was a residential deaf school in nearly every state (Nomeland & Nomeland, 2012). Residential schools for the deaf often required children and adolescents to move far from home and to stay on campus for the majority of the year (Nomeland & Nomeland, 2012). It has been argued that residential schools offered a sense of family, as a consequence of the separation from biological families and connection with Deaf community, like peers and an alternative to mainstream education (Padden & Humphries, 2005). However, others argued that residential schools for the Deaf isolated the children from the mainstream world (Padden & Humphries, 2005). As a consequence, in the 1970's there was a shift towards mainstreaming children with disabilities into their neighborhood schools which generalized to the integration of Deaf children into mainstreamed classrooms (Padden & Humphries, 2005). Even though this was viewed largely as a progressive movement towards developing more services and educational experiences for the Deaf, Padden & Humphries (2005), argue that it hindered opportunities for deaf children to develop their Deaf identity. Specifically, this loss occurred due to the reduced

number of Deaf children in the school, which removed a sense of Deaf community and Deaf role models.

Providing Professional Services to Deaf Persons

Historically, deafness was viewed as pathological in nature (Klinger, 2007). Typically deaf persons have been framed by health professionals through the lens of the medical model, which does not acknowledge disability as an identity variable (Olkin & Taliaferro, 2006). Generally there are three models of disability, which are the moral, the medical and the social model (Olkin, 2009). The moral model views disabilities as a punishment from God and disability is the fault of the person or their family (Olkin, 2009). The medical model frames disability as an abnormality and thus focuses on the disease or disability as something to heal or fix and when a cure is not an option, to promote an appearance of normalcy (Olkin, 2009). While not overtly stated in either the moral and/or medical model, disability is conveyed as something inherently bad and produces feelings of pity, shame and blame within that individual and from the ablest population. Conversely, the social model contextualizes disability as a socially constructed experience that has been largely defined by social narrative and normative assumptions that are often marginalizing and oppressive (Olkin, 2009). This model argues for a social justice response and the need for recognition of disability as a viable identity variable (Olkin, 2009). Consequently, the social model focuses intervention strategies at the systems level, to promote social change rather than change in the individual (Olkin, 2009). Individual interventions are geared toward promoting resilience and empowerment within members of the disability community. Towards this end, affirming therapy techniques modeled after Gay Affirmative Therapies have been

suggested. And yet, competence in disability affirming therapy is not the norm (Olkin & Taliaferro, 2006).

When considering therapeutic approaches relative to Deaf individuals it is important to remember that most Deaf persons do not consider their deafness a disability, except within the context of the majority population inhibiting them through discrimination, stigmatization and physical barriers (Nomeland & Nomeland, 2012). In this sense, Deaf communities were well ahead of the disability rights movement in psychology which suggested we needed to change the lens by which we look at and treat disability. A report on the mental health needs of Deaf persons discussed how members of the Deaf community do not view their deafness as something to be fixed, hidden or overcome (Critchfield, 2002). Historically, mental health services have been poorly equipped to address the specific needs of Deaf persons because providers often make the assumption that what works well within the hearing population is applicable to the Deaf population (Padden & Humphries, 2005). Inclusive mental health services are far behind that of mental health services for hearing individuals in accessibility and quality, leaving many Deaf persons receiving poor treatment or none at all (Padden & Humphries, 2009). However, recently there has been more acceptance and acknowledgement of the Deaf community by the majority population (Klinger, 2007).

LGBQ and Deaf

A review of the literature pertaining to Deaf persons shows that little is said about intersecting identity variables within the LGBQ community within the Deaf community. Nomeland & Nomeland (2012), devote one small section to “diversity in Deaf culture” which simply listed out diversity factors, excluding sexual orientation. Ladd (2003)

included a similar diversity section that merely stated that there is little research on LGBTQ Deaf persons and that groups of LGBTQ Deaf are on the rise. And yet, Grossman (1972) found that homosexual behavior is reported more in the Deaf population. The implication of this statement is not clear, given homosexual behavior is not equivocal to sexual orientation. And yet, attention about sexual identity and practices is warranted to address the unmet needs of members of the Deaf community who are LGBTQ. However, there is no way to quantify the number of LGBTQ Deaf individuals given the high rate of underreporting and lack of research (Klinger, 2007).

The commonalities between LGBTQ and Deaf persons are significant. Both are typically viewed as “less than” by the dominant hearing and heterosexual population, experience isolation and invisibility by the larger culture and within their own families and have been labeled by health professionals as unnatural (Gianoulis, 2009).

Historically, both groups have been pushed to become “normal” whether by speech and hearing therapy or mental health interventions. The marginalization of Deaf and LGBTQ persons have created a protective social response to form cohesive Deaf communities that associate pride with their deafness (Gianoulis, 2009). Even though there are great similarities, neither group has advocated for each other towards creating an inclusive environment for both within their respective groups even though some studies have shown a larger rate of non-heterosexuals within the Deaf community (Gianoulis, 2009). Langholtz & Rendon (1991) further note that LGBTQ and Deaf persons have not grown up with explicit or easy access to role models. Both groups experience a lack of family support because they are often born with parents whom are neither Deaf nor LGBTQ (Klinger, 2007). When these two identities combine, it is hard to imagine the difficulty

in disclosing or discussing one's sexual identity with parents who do not use sign. Umans (1984) wrote that these two groups should be "natural allies" given that they both found their pride and action in response to similar oppressive forces and around the same time period. And yet, he also states that both groups have shown the same "ignorant prejudices of the majority against each other" (Umans, 1984).

Given that LGBTQ and Deaf have similar oppressive experiences, there should be literature and research that speaks to the experience of how these variables combine. Barthell (1983) clearly asserts that those who identify as LGBTQ within the Deaf community are being ignored by the researchers whose work is focused on deafness and that the need for research in this area as well as deaf sexuality in general is immeasurable. Barthell (1983) speaks to the double minority status and how society already ignores the sexuality of disabled persons and thus homosexuality is nearly nonexistent. O'Toole (2000) interviewed disabled women (not specifically Deaf) and found that these women felt that their sexuality and sexual orientation were rarely addressed by the disability rights movement. Not only have issues of sexual diversity been ignored, there has been research to show that there are derogatory American Sign Language (ASL) signs used within the Deaf community in reference to LGBTQ persons (Langholtz & Rendon, 1991; Rudner & Butowsky, 1981). Rudner and Butowsky (1981) conducted a study with Deaf participants of varying sexual orientations. The researchers showed participants assorted photographs depicting slang, degrading and proper ASL signs of "gay, lesbian" or equivalents. They also measured the participants' attitudes regarding the use and meaning of the signs. The results showed that there are signs exclusive to LGBTQ Deaf persons and that the heterosexual participants did not know the difference between "acceptable" and

“offending” signs (Rudner & Butowsky, 1981). This depicts a conclusion that some heterosexual Deaf persons are uninformed about the appropriateness of signs and hold negative attitudes towards LGBTQ members in their community. Langholtz & Rendon (1991) discuss that sexuality is not an “open” topic within the Deaf community or in their home, which leaves even fewer resources for LGBTQ Deaf persons. Langholtz & Rendon (1991) go on to communicate that Deaf persons find it very difficult to disclose their non-heterosexual orientation and often fear contempt from other Deaf members of the community. Phaneuf (1987) describes “coming-out” as a three-step process that entails coming-out to oneself, friends/family and society. However, within the cohesive Deaf community the fear of being exposed to everyone can be very real given that news travels very fast and there might be those with negative views of homosexuality in the Deaf community (Phaneuf, 1987). He also discusses the limited accessibility to information about homosexuality and the idea that this can cause many misconceptions about sexuality for Deaf persons and leaving them without a true sense of their sexual identity.

Research that encompasses the varying issues of those whom identify as LGBTQ and Deaf is limited in quantity. Zakarewsky (1979) conducted a study that surveyed professionals whom served the LGBTQ and Deaf communities and found that it was undoubtedly a population that needed distinct services. The few research articles found during this literature review that did address LGBTQ and the Deaf community were mostly composed of homosexual male participants. Given our society’s emphasis on conducting research on males and later applying it to women, or conducting research on the hearing population and later applying it to the Deaf, it is not surprising to see this same trend when LGBTQ and Deaf identities intersect. A study conducted by Leblanc and Tully

(2001), explored that social support systems of LGBTQ Deaf persons. Results indicated that most LGBTQ Deaf persons turned to lesbian or gay friends in times of crisis and that a majority of the participants never used mental health services. Leblanc and Tully (2001) concluded that it is essential that this subgroup be further studied as it is not yet understood nor recognized. Mallinson (2004), conducted research with five Deaf gay males whom were exposed to HIV/AIDS. “They described living at the intersection of multiple communities, the deaf, gay and hearing, each characterized by unique communication styles, cultural expectations, and a propensity to marginalize outsiders” (Mallinson, 2004). Complaints that these five men had in regards to HIV/AIDS information were that educational materials were not satisfactory due to inappropriateness of the use of only written materials and that staff within the health care field were cruel, uncaring and unaware of the particular needs of Deaf gay persons (Mallinson, 2004). Mallinson conducted thorough, open-ended interviews with each of the men, coded their transcripts for themes with help of a deaf gay man whom was a consult for the research project and pulled congruent themes across their stories. The themes that emerged included being ill informed about illness (HIV/AIDS), representing a minority within a minority, multiple AIDS related deaths and ineffective health care response (Mallinson, 2004). The following chart is provided from Mallinson (2004) and describes the experiences of the men interviewed in a holistic manner. Overall the men reported feeling like a minority in every community and reported being made fun of by heterosexual Deaf persons whom degraded them (Mallinson, 2004).

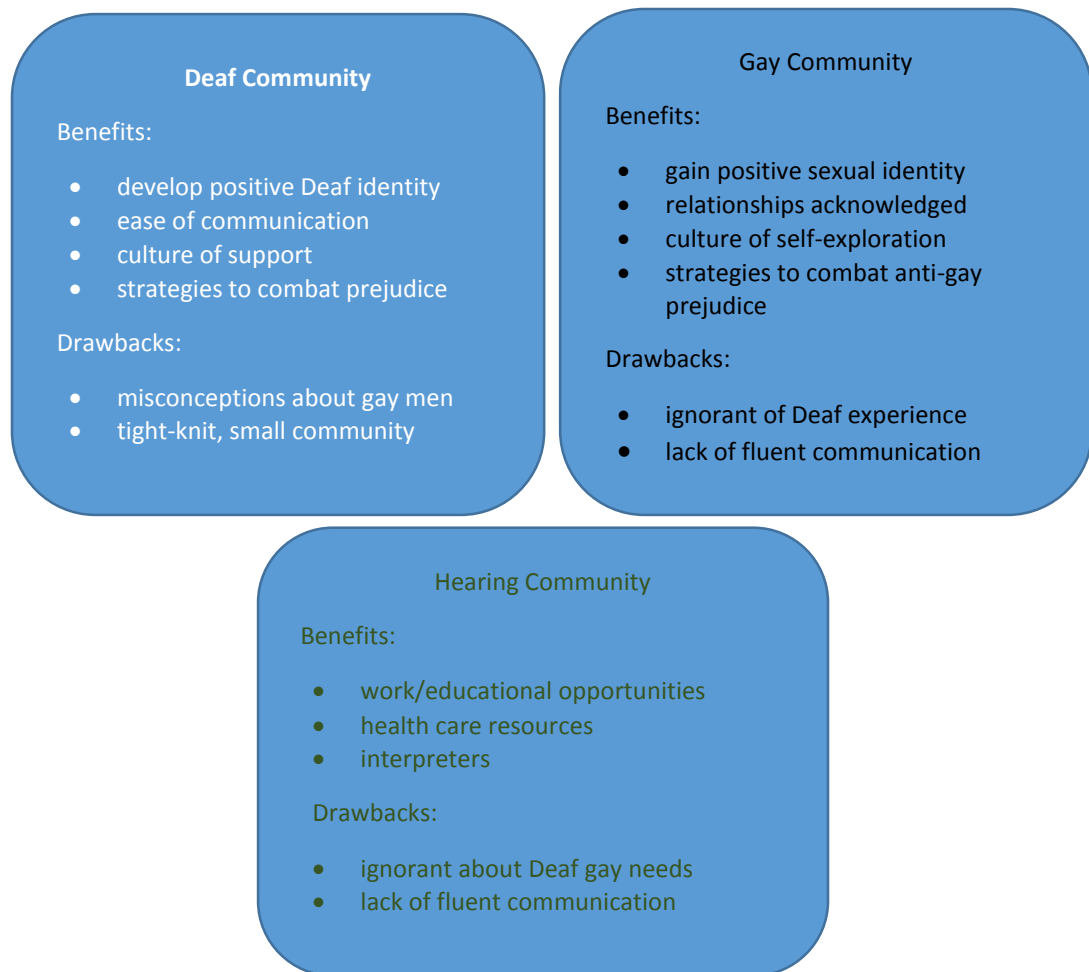


Figure 1. Mallinson chart.

Doyle (1995) conducted a study that measured general AIDS knowledge, AIDS related issues, sexual behavior, safe sex practices, number of sexual partners and sources of AIDS info of 84 Gallaudet college students. The researched showed that many of the students held high knowledge about AIDS, had high rates of sexual activity, 50% condom use and that most learned about sex from peers.

Klinger (2007) conducted a research study measuring various aspects of LGBQ Deaf psychosocial development. Her study included 58 participants whom identified as LGBQ and Deaf. Klinger (2007) developed an electronic, English, survey. Klinger (2007) found that participants that were more immersed in Deaf culture were more

comfortable with their sexual identity. However, upon investigation of the survey questions, it is hard to decipher which questions were truly measuring comfort level with LGBTQ status. Another finding of this study was that the more sexual knowledge a person had, the higher the likelihood that the person disclosed their sexual orientation to family members (Klinger, 2007). Although this study is clearly revolutionary given the very limited research on this population, it should be noted that the survey was not standardized, nor was it in ASL, which the author noted were limitations of the study. Klinger (2007) stated that more research and specific organizations for this subculture, such as Rainbow Alliance of the Deaf, must be developed. This researcher hopes to elaborate more on the intersectionality of LGBTQ and Deaf identities in the future.

Zangas (2005) conducted a study where he measured level of homophobia in the Deaf community by surveying 174 Deaf and hard of hearing, heterosexual individuals across the Northeastern region using The Attitudes toward Lesbians and Gay Men Scale. The researcher revised this scale to be applicable with Deaf persons by simplifying the language and testing the original measure on a group of Deaf individuals and made edits via feedback received. Zangas (2005) found that those whom he surveyed had a moderately positive attitude towards lesbian and gay men. This study was very progressive in that it involved two identity variables that are poorly researched. However, I would assume that many Deaf-Gay/Lesbian individuals may view homophobia differently than their heterosexual cohort. Also this study did not include any attitudes about bisexuality or other non-heterosexual individuals.

Sex Education Experiences of Deaf and LGBTQ Persons

Sexual education in the United States school systems began in 1913 when the American Social Hygiene Association supported its implication (Elia & Eliason, 2010). The premise was to help prevent social disease, for sex education to emphasize the importance of heterosexual marriage values and to provide reproductive focused sex education (Elia & Eliason, 2010). During this time era women were seeking sexual eradication, divorce rates were on the rise and conservatives were concerned with the morality of the nation (Elia & Eliason, 2010). Mental health professionals also played their part in hindering accurate sexual education by labeling masturbation and sex outside of marriage as impure (Elia & Eliason, 2010). Local and state school officials determined sex education curriculum until the 1980s when the federal government became involved (Elia & Eliason, 2010). Three major federally funded motions were passed in order to manipulate sex education in the schools. In 1981 the Adolescent Family Life Act was passed with intentions to prevent teen pregnancy and promote abstinence only sex education (Elia & Eliason, 2010). In 1996 Title V of the Social Security Act provided monetary funds for schools that agreed to provide abstinence only education (Elia & Eliason, 2010). In 2001 the community-based abstinence education used scare tactics and heterosexual ideals to promote abstinence only in schools (Elia & Eliason, 2010). Not only does abstinence only sexual education promote homophobia and oppression but also is not empirically supported as an effective method to prevent teenage pregnancy (Elia & Eliason, 2010). The Alan Guttmacher Institute conducted three nationwide surveys in 1988 that found that most sex education covered abstinence, birth control/condoms and

STD information (Donovan, 1989). Needless to say, same-sex education was not being taught.

Recently there have been advocates for the inclusion of LGBTQ issues in public sex education. In 2000, The Department for Education and Employment published *Sex and Relationship Guidance*, which calls for sex and relationship issues to be addressed in school's curriculum (Donovan & Hester, 2008). Donovan & Hester (2008) state, “ the government's guidance on sex and relationship education provides a rationale for including same-sex relationships when it says that schools should meet the needs of all their pupils, ‘whatever their developing sexuality’ and be relevant to them and sensitive to their needs” (p. 277). Donovan & Hester (2008) conducted a study in the United Kingdom where they interviewed 67 couples of mixed heterosexual and homosexual identities and found that being under the age of 25 was associated with a higher risk of experiencing domestic violence. Their rationale to include same-sex relationship and sex education was based off the findings that because young persons were not receiving education about same-sex sexual activity or what to expect in same-sex relationships, and therefore did not know how to distinguish between healthy and unhealthy relational patterns.

LGBTQ are not the only community excluded from inclusive sexual education. Residential schools of the Deaf have struggled with sex education issues for many years and often practiced gender segregation in schools. Phaneuf (1987) also highlights the issue of Deaf children not having any formal instruction on sexual topics and that residential schools often segregated males and females so there was little chance for interaction and sharing of knowledge. Gabriel & Getch (2001), report that deaf students

are more sexually active, have higher pregnancy rates and use birth control methods less frequently than hearing peers according to various sources cited within this work. In residential settings, there have been discussions of more frequent sexual abuse as well by peers and teachers. Mansell (1993) reported that 50% of deaf women and 54% of deaf men are sexually abused as children. Suter, McCracken & Calam (2009), surveyed teachers of the Deaf whom reported that various language levels, lack of specific training and lack of appropriate materials as the top three most difficult challenges to teaching sex education to Deaf students. They also found that less than 6% of the teachers had received any type of sex education training, yet all teachers rated it as very important. There is a clear deficiency between a recognized need and implementation of services. Job (2004) conducted a literature review of sexuality and deaf for the past 40 years and found that lack of communication between the parents of deaf children and their children, lack of sexual education in school and insufficient language were the main factors in lack of sexual knowledge. She also speaks to the lack of opportunities that deaf children have to learn about sex compared to their hearing peers who can learn by overhearing conversations or watching TV, calling for the necessity of more formal education to address the gap in knowledge. As early as 1982, another researcher, named the problem as multilayered in that there is a lack of sex education at home and within school which in turn leaves Deaf children with no one to get information from besides peers whom are most likely ill-informed as well (Lewis, 1982). He goes on to discuss that a major problem lies in the fact that the teachers are uneducated in how to teach sex education and that they are unwilling to teach it as well due to discomfort with the topic (Lewis, 1982). Schirmer (2001) noted multiple reasons why parents do not initiate conversations

with the children about sex including lack of language skills, embarrassment, awkwardness, fear of promoting sexual activity, believing their children already know and that the responsibility should be that of the school.

With minimal formal sex education, little interaction with the opposite sex and no formal LGBTQ sex education, it is no wonder Deaf children are left feeling confused and without a sense of sexual identity. This researcher struggled to find identity models that incorporated more than one identity. Singular models fail to incorporate the important aspects of holding multiple identities (Butler, 2012). Most articles are male-focused, disability general and lack any research on bisexuality (O'Toole & Bregante, 1992). There is a lack of knowledge and research about how LGBTQ identity and Deaf identity interact. "At any one time, an area of social difference may be more significant to an individual than at another time. For someone with a disability who is also a sexual minority, either of these could be more significant depending on that time in the person's life, contemporary significant event or the context. The challenge of writing and working in this area is to hold multiple identities in mind and consider their interaction" (Butler, 2012, p.156). Garnets (2002) discusses that having multiple identities inherently creates conflict in that the person will have to navigate between the different values of different communities. What happens when one minority status silences the other minority status in an individual or the majority population silences both? One disabled lesbian interviewed by O'Toole (2000) stated, "Disability sets you apart from other queer women. Sexuality sets you apart from other women with disabilities. It's easy to feel very, very isolated" (p. 208).

Participatory Action Research

Participatory action research (PAR) addresses the gap between researchers and the intended beneficiaries of research, meaning those who are being studied, are involved in the research process to maximize the benefits and relevancy of the research (McTaggar, 1991). PAR is a model that is used to include the opinions of those being researched into the process alongside the researchers (Turnbull, Friesen & Ramirez, 1998). This approach is commonly used with disability and rehabilitation research (Turnbull, Friesen & Ramirez, 1998). This can be equated with the disability mantra of “nothing about us without us” (Charlton, 1998). Five benefits that Turnbull, Friesen & Ramirez (1998) reference in terms of PAR are an increase in relevance of the research, increased thoroughness of the research, minimization of logistical problems, increased utilization and enhanced empowerment. There often can be difficulty in getting research established in certain communities or populations. Doyle (1995), a Deaf researcher, discusses that confidentiality issues are more prominent in the Deaf community due to oppression experienced by the hearing world and because of the close-knit style of the community. Doyle carried research consistent with the tenants of participatory action research. For example, Doyle (1995) developed a questionnaire designed to look at the AIDS knowledge in Deaf undergraduate students. In doing so, instead of using existing measures that were not originally created for the use within the Deaf community, he created measures that were culturally congruent to the Deaf community. Further he explained, to simply rewrite existing measures would be inappropriate given English does not translate verbatim with American Sign Language. Doyle (1995) developed his questionnaire through an extensive literature review, and then he obtained a review by an

AIDS specialist physician and a native Deaf ASL individual to further assure the measure was appropriate for the Deaf community. He continued a process of soliciting feedback from deaf community members before arriving at the final version of this measure. Specifically, after the initial version was written, he then pretested his questionnaire with deaf undergraduate students and used their feedback to revise the questionnaire. Additional revisions to the questionnaire were performed after completing back translations to ensure consistency. These practices are at the core of participatory action research.

This study uses elements of PAR principles in that, the researcher developed the questions for use with the LGBTQ/Deaf community with input from experts in the Deaf community and Deaf community members. Specifically, questions were shaped by these interactions as well as the hypotheses. The researcher does identify as a member of the LGBTQ community, and as an ally to the Deaf community. Committee member Susan Fraker is an expert in the Deaf community. Dissertation Chair, Julie Williams is also an active member in disability rights issues and identifies as a woman with a disabilities including moderate to severe hearing loss.

This literature review informs the conceptualization of the multifaceted problems faced by Deaf LGBTQ individuals. The problems identified include, the lack of research conducted with the LGBTQ/Deaf population, the lack of inclusive sex education for both communities, the lack of information about dual identity formation and discrimination experienced in the hearing world, the straight world, the LGBTQ community and the Deaf community.

Chapter III: Methods

Goals

This proposed study had several intended goals. The first goal was to gather demographic information about LGBTQ/Deaf individuals in a Midwest town. The second goal was to gather qualitative data about LGBTQ/Deaf experiences in the LGBTQ community and Deaf community, his or her coming out process, discrimination and sex education experiences. The third goal was to receive input from LGBTQ/Deaf persons as to what can be done that would foster their sexual identity development and health. Hypotheses were informed by the literature review and with the input of persons with 25 years of experience and allyship within the Deaf community and Deaf community members alongside the researcher (See Participatory Action Research). The first hypothesis was that formal inclusive sex education for the LGBTQ/Deaf population was not provided or when provided was irrelevant and inadequate in relation to both deafness and sexual diversity. The second hypothesis was that if a person identified with the Deaf community than they were less integrated into the LGBTQ community and vice versa. The third hypothesis was that Deaf/LGBTQ persons would report experiences of marginalization and discrimination within both the LGBTQ and Deaf communities.

Materials

A list of sixteen questions was developed for the focus group in order to gather qualitative data about the experiences of Deaf LGBTQ individuals along with demographic information (See Appendix A). The demographic questionnaire was designed to collect

age, gender, race/ethnicity, sexual orientation, current education status, and type of preliminary school (residential, mainstream, homeschool or other). The focus group questions were developed to address the specific experiences of marginalization, discrimination, oppression, and acceptance within the Deaf community of one's LGBTQ sexual orientation. As stated previously, the questions were developed with the input of persons working in the Deaf community for over 25 years and members of Deaf community alongside the researcher in order to address issues relevant to the community. At the end of the focus group participants were asked to provide any additional information or suggestions regarding issues not addressed in the focus group questions. Specifically, participants were asked to provide any additional questions or areas needing to be addressed that were not, which is consistent with the PAR Model.

A focus group is a small-group discussion about a specific topic and in this case would be the experiences of Deaf LGBTQ individuals. The benefits of using a focus group in order to collect data is that it allows room for the participants to express their answers in their native language, American Sign Language, and allows the researcher to gather data on what this population needs, directly from the source. Group discussion is an important aspect of a focus group because it allows the participants to steer their own dialogues and exploration of salient issues connected to and triggered by the open-ended question and further generated by the ensuing dialogue among group members (Kitzinger, 1995). An online survey would prevent individuals from expressing their views using their native language which in and of itself could impede understanding of the questions and / responses as well as stifle the authenticity of their responses. Also, an online survey would not allow for the depth and breadth of responses generated by the

discussion that occurs among group members using a focus group method. Focus groups are also considered a starting point in research, especially with a population that has not been studied or is misunderstood and in this case largely absent from the literature. In this study each focus group member completed a consent form agreeing to participate in the focus group as well as being audio taped. Two fluent American Sign Language interpreters were utilized to voice the responses of the participants into an audio recorder. In addition, there was a co-facilitator who assisted in cultural interpretation and reframing of questions as needed.

Participants

Recruitment was conducted through distribution of a flyer and word of mouth. A member within the Deaf LGBTQ community personally invited participants for the focus group that she knew were Deaf LGBTQ. The selection criteria for the study were restricted to persons identifying as deaf and identifying as either lesbian, gay, bisexual, queer or questioning. Transgendered individuals were not included in this study in order to respect the need for additional research that captures the unique needs of the transgendered population. The focus group consisted of three Caucasian, self-identified lesbians. Two of them attended a mainstreamed school and one attended a Deaf school. Their ages ranged from 40 and older. Two earned a high-school diploma or GED, and one earned an associate's degree.

Procedure

Human subjects' approval was obtained through Institutional Review Board (IRB) at Wright State University Department of Research. Challenges were encountered during the recruitment phase in obtaining participants for the focus group. Initially, seven

participants agreed to participate in the focus group, but due last minute scheduling conflicts, only three persons attended and participate in the scheduled group. Written consent was obtained from each member of the group on their arrival to the group session and prior to commencing the focus group. The focus group was facilitated by the researcher and a co-facilitator, whom is hearing and fluent in American Sign Language. The co-facilitator has been immersed in the Deaf community as a licensed social worker and actively works with Deaf community members conducting therapy. The co-facilitator's knowledge of Deaf culture and direct experience with this population served to assist the researcher in reframing questions and translating context, as well as content. The two interpreters were recruited by the co-facilitator for their accuracy with American Sign Language interpretation and interest in the project. In addition, the co-facilitator helped clarify questions and reframe them as needed for the participants' understanding. The two interpreters voiced the responses of the participants into an audio recorder. The researcher transcribed and summarized the participants' responses for themes. Additionally, the researcher's advisor, a psychologist, was present for the focus group and also added commentary to the process. The advisor identifies as a disabled woman.

Chapter IV: Results

Participants

Three women participated in this study's focus group. All of the participants completed the self-administered questionnaire. All three participants self-identified as Deaf, lesbian women. Each participant identified as Caucasian. Two participants attended a mainstreamed school, while one attended a school for the Deaf. Two participants reported earning a high school diploma or GED equivalent. One participant reported earning an associate's degree. The age ranges of the participants were 40-years and older.

Focus Group Question Responses

All of the questions were addressed in the focus group. Below are summarized responses from the participants. Their responses were audio taped and the responses were grouped into repeating thoughts. Underlying themes were identified which will be discussed in the discussion section. All of the questions were asked as open-ended questions in order to gain qualitative data that reflects the lived experiences of LGBTQ Deaf individuals. Therefore, this data is not conclusive, but rather a starting part in understanding and adding to the limited literature regarding this subpopulation. The researcher and co-facilitator often reframed questions for clarification and to prompt further discussion.

Are you currently out as LGBTQ in the Deaf Community? Two participants reported they were out as lesbians within the Deaf Community, while one did not.

What was your coming out process like within the Deaf community? None of the participants reported a “coming out story”. The two women who identified as “out” in the community, reported that they do not disclose their sexual identity, without first being directly asked. One woman disclosed that she kept her sexual identity secret for six to seven years. She reported that because of the nature of her job, she felt the need to keep her sexual identity private for fear of losing her job, or losing privileges and roles within her job. She also stated, “It (her sexual identity) was not important enough to talk about”. This same woman discussed how she has experienced others talking about her and her sexual identity without her knowledge.

What was your coming out process like to your family/friends? Two of the women spoke to the experience of telling their family members and reported mixed acceptance and feelings of judgment. One woman discussed that she has not told her family for fear of rejection. She discussed that she was raised in a religious environment and she feels her sexual orientation is “between her and God”. One woman discussed that she did not need specifically come out to family members or friends, because they see pictures on Facebook of her and her partner. The women discussed that most persons don’t simply ask them, “Is this your girlfriend”? One woman spoke to the experience of acceptance from her small group of close friends.

Who did you first disclose your sexual identity to and why? This question was asked however, interestingly the women did not identify with a specific “coming out” story that was salient to them.

Do any of you identify as religious/spiritual and what messages you learned about being deaf or LGBTQ? Two of the women discussed that they grew up Catholic. They spoke to being forced to attend church and feeling judged by the church and their family. One woman particularly struggled with this topic of conversation and the oppression she continues to feel due to religion in regards to her sexual orientation. The women stated that they heard messages about lesbianism being a sin. One woman discussed that she believes in God and prays and hopes that God accepts her for who she is. She discussed that she is concerned about the conflict between her religion and her sexual orientation. She stated, “I just try to have faith and keep going”. One woman discussed that she feels a lot of Deaf persons are religious and she is unsure how they view LGBTQ person. In regards to deafness, the women did not report many negative messages from their religion. One woman told a story of how her brother “tried to make” her hearing and she attended a religious revival. They told her that she “had to have faith”. The revival did not make her hearing. Another woman spoke about how her mother felt guilty for her deafness.

Have you ever felt excluded from the Deaf or LGBTQ community? These two questions were addressed together in the focus group. None of the women were actively involved in the LGBTQ community and did not report any instances of discrimination due to their deafness, when they did participate or were around hearing LGBTQ persons. One woman stated she felt like the hearing LGBTQ community was actually motivated to

learn sign and that she felt more comfortable and acceptance when around hearing LGBTQ persons. The women discussed that they were too busy to attend LGBTQ events. One woman stated that her sexual orientation was such a small part of her life and that she preferred attending and being involved with the Deaf community instead. One woman emphasized that her primary locus of identification and membership is within the Deaf community and that was her priority. The women again spoke to hiding their sexual orientation from the public, and from the Deaf community. They discussed being worried about their reputation, or people treating them poorly if they knew. They discussed not knowing who they could trust and feeling fearful of being affectionate in public.

Are you active in the Deaf and/or LGBTQ Community? These questions were addressed together in the focus group. All of the women are active in the Deaf community, to varying degrees. Once again, the women emphasized the Deaf community as their main focus and participating in advocacy. They spoke to a shift within the Deaf community of possibly more acceptance of LGBTQ persons. The women discussed how younger generations of Deaf LGBTQ persons are more open about their sexual orientation.

Have you ever been involved with any type of Mental Health Services? If yes, please explain your experience including discrimination, difficulty of accessing services and general treatment as an LGBTQ Deaf person. Two women denied ever receiving mental health services. The woman who had engaged in mental health services, had a therapist who was hearing, but culturally knowledgeable about the Deaf community and was fluent in American Sign Language. She reported feeling accepted as a Deaf lesbian. The women discussed how difficult it is to find a therapist whom is fluent in American Sign Language. They reported relying on word of mouth, as to who is safe to

see. All of the women reported preferring a therapist who is fluent in American Sign Language. They discussed that it can be shameful or embarrassing to have an interpreter in the room while sharing such intimate details of your life. One woman discussed that she feels like many Deaf individuals cannot find adequate mental health services, so they do not engage. She also reported that she would feel more comfortable if she was able to choose the person who would interpret in the sessions, while at the same time, how hard it is to find an interpreter you can trust. They also discussed that if there is a fluent ASL therapist, you probably know him/or her in the Deaf community as well, which can make things uncomfortable. One woman discussed an experience with a school counselor who also forced her to be oral. She reported feeling uncomfortable and unable to trust them. She reported that they told her it was hard to understand her and that she needed to learn how to speak English.

Did you ever receive formal sex education and what type of school did you attend? All of the women recalled some type of formal sex education. They all remembered that it was specific to heterosexuals and that abstinence was taught. Two women attended a mainstream school, with deaf classrooms that were taught in American Sign Language. The other woman was also mainstreamed, but was forced to be oral. They reported having no LGBTQ role models or receiving information about non-heterosexual sex or relationships. They reported learning about sexual safety from friends, some of who were diagnosed with HIV. They reported attending workshops through the AIDS Resource Center as well. They reported wishing that “the word would have been spread”, regarding how to use condoms and other contraceptives during school. The woman discussed wanting more education growing up. One woman

discussed not identifying as a lesbian until college and that when women began to hit on her, she did not understand why because she had never heard of a lesbian. After being questioned about the difference between receiving education and receiving permission to explore sexual identity, the women noted that they did not have the opportunity to explore their sexual orientation in a safe way while growing up. One woman spoke to hearing about girls at school who liked other girls, and that they were afraid of being punished for their feelings. They discussed that people were closed minded and lacking in acceptance. One woman spoke about being jealous of San Francisco, and how being LGBTQ there is almost “normal”.

10. How do you think your lived experience is different from a deaf straight person? This question was not originally included in the list of questions to be asked, but due to the participant’s responses and cultural context, this question was asked. One woman discussed that when she got divorced and she came out to her friends, that they never heard of a lesbian. One woman stated, “Deaf is Deaf and that’s all that matters”. They did not report their lived experience as being different from a Deaf straight person. At one point, a woman did say that being a Deaf lesbian is like “double stigma or double label”. However, she followed this up by saying that everyone experiences discrimination and that it’s not additive. The women had a discussion about whether or not the majority of the Deaf community, or their Deaf friends, colleagues would attend a lesbian wedding. The women reported that they felt some people would be hesitant to attend.

They discussed the small, close-knit community of the Deaf and if they disclosed their sexual identity to one person, then everyone would know. They reported a

preference for hanging out with hearing lesbians. One woman reported not trusting the Deaf lesbians in their geographic area.

11. How was this process for you? Was there anything that wasn't asked that you feel is important to talk about? The women discussed the need for more education for Deaf LGBTQ individuals and specialized services as well. They spoke to the need for more diversity education and training. One woman discussed that participating in the focus group allowed her to learn more about herself and makes her question herself. They discussed needing more resources and activities that engage Deaf LGBTQ youth and their hearing parents. They spoke to a need for specialized sex education while in high school. They discussed the focus of others on “fixing” or accommodating their deafness and a lack of acknowledgement of their other diversity variables. They stated that they wish younger Deaf LGBTQ persons could have been present for the focus group and a desire to learn about their experiences.

Chapter V: Discussion

Identified Themes

The results from this study were consistent with the three hypotheses identified by the researcher. First, there is a lack of inclusive and adequate sex education, second, identification with one community will be more salient than the other, and third, there are a greater number of reported experiences of discrimination within this population. In addition, three primary themes emerged from the results of this study. Firstly, the participants endorsed attitudes consistent with internalized oppression regarding sexual identity. Secondly, participants lacked sexual education and thirdly, participants' Deaf identity was more salient than their sexual identity. These themes are consistent with those found in the literature. The following section explores these themes further and identifies points of convergence with the literature. Suggestions for future research directions and the clinical implications of these results are also discussed.

The first theme identified was internalized oppressive beliefs regarding sexual identity. Internalized oppression is the process by which a member of a devalued minority group adopts the negative attitudes and beliefs about one's minority status as part of his or her own self-system (Szymanski & Kashubeck-West, 2008). The process of internalized oppression occurs as a consequence of being subject to negative messages about one's minority status on a daily basis (Sue, Bucceri, Lin, Nadal, & Torino, 2007).

LGBQ individuals represent another group vulnerable to receiving constant negative messages regarding their sexual orientation from a variety of sources in their lives (Szymanski & Kashubeck-West, 2008). Indeed, family, friends, society, and institutions may engage subtle microaggressions or overt acts and statements of oppression. Over time, the cumulative impacts of these messages, may negatively effect their thoughts and feelings about their sexual identity and develop into internalized oppression resulting in a rejection of this part of themselves. The additive theory of internalized oppression states that each oppressed minority status has an additive effect, meaning that the negative impact on psychological health increases in proportion to the number of oppressed identities within an individual (Szymanski & Kashubeck-West, 2008). Internalized oppression can take the form of feelings of low self-worth, shame about sexual identity, active self-loathing, anxiety, depression and/or subtle avoidance of discussing this part of their lives.

The participants in this study, had difficulty identifying and articulating discrimination they had experienced due to sexual orientation. Questions were reframed and clarified by the researcher and co-facilitator in order to facilitate comprehension of the questions being asked regarding discrimination. Despite denying overt experiences of discrimination the women in this group described actions taken, to comfortably exist in a heterosexist environment suggesting that discrimination may have been occurring and that these women had learned to accept these experiences as normative. For example, the group members shared stories in which they had learned to hide their sexual orientation from others in order to avoid negative consequences within their families, work settings and even in the context of ensuring their safety. Their stories suggested that hiding their

sexual identity allowed them to avoid experiencing negative judgment from others, though they did not have the explicit insight that this was a motive for their behavior.

According to a social constructionist perspective on sexual identity formation, the desired end stage of identity formation is to have a positive perspective on one's sexual identity and an acceptance of diversity within oneself (Horowitz & Newcomb, 2001). While the group members did not directly express negative beliefs about their sexual identity, they did not convey the same degree of identity pride that was associated with their Deaf identities. None of the participants provided examples of coming to know oneself as a sexual minority and the relief of living more authentically in relation to their sexual identity. The women did not share "coming out" stories, as they defined their sexual identity as insignificant. According to McCarn and Fassinger (1996) the third phase of sexual identity development is a process of deepening and commitment, "which is marked by a commitment to make a personal relationship to the reference group and the possible consequences of doing so, in addition to a deepening awareness of the value and the oppression of the lesbian/gay community" (p. 522). All three of the women had not shared their sexual identity with many people outside of their immediate families and even with family members, they did so only when directly asked. According to the aforementioned models of identity development, the participants in this study have not connected to the LGBQ community and may not understand the oppression that they, or their community have faced due to sexual orientation status.

Given that these models tend to be singular identity models, it may be that the complexity of multiple identities is not captured within them, nor the specific challenges LGBQ Deaf persons face within the Deaf community. For example, Langholtz & Rendon

(1991) discussed that Deaf persons struggle to openly disclose their sexual orientation due to anticipated negative judgments from Deaf community members. According to these authors the risk of negative judgments from the Deaf community may be more important than negative judgment from the hearing world. This is consistent with the experiences of the three women in this study, who acknowledged a fear of telling even just one person within the Deaf community, because it meant “everyone in the Deaf community would know their sexual orientation the next day”. This has also been noted in the literature by Phaneuf (1987) who emphasized how the closeness of the Deaf community creates fear in those who identify as LGBTQ with whom it is safe to share one’s sexual identity.

The lack of awareness about the complexity of multiple identities was evident in some of the participants’ responses to questions. The women were asked to consider how their lives are different from heterosexual Deaf persons. One woman initially stated that it was like a “double label”. However, she immediately backtracked and stated, “Everyone experiences discrimination”. There appeared to be a lack of awareness of how one’s sexual orientation may affect one’s status within a community. This woman seemed to hold the belief that because everyone experiences discrimination, her unique experiences were insignificant. Once again, oppression was conveyed as a normative experience and therefore to be accepted. This is consistent with research about microaggressions, which has historically focused on the experiences of racial and ethnic minorities (Platt & Lenzen, 2013). According to Sue, Bucci, Lin, Nadal and Torino (2007), “Racial microaggressions are brief and commonplace daily verbal, behavioral and environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or

negative racial slights and insults to the target person or group” (p. 72).

Microaggressions also occur within the context of sexual minorities as well. The women in this focus group most likely have been repeatedly exposed to microaggressions throughout their lives, and have thus internalized these messages and hence identify them as normative. In addition, research has shown that the presence of quality social support can serve as a buffer to psychological distress and the negative effects of internalized oppression (Szymanski & Kashubeck-West, 2008). The participants, as noted later in the discussion, did not strongly identify with the LGBTQ community and therefore are not receiving potential additional social support and resources related to sexual orientation.

The second identified theme was a lack of inclusive and adequate formal sexual education. The participants all agreed that they did not receive adequate and inclusive sex education, which is consistent with the literature for both the Deaf and LGBTQ community (Phanuef, 1987; Job, 2004). The participants discussed that they were taught sexual abstinence and non-heterosexual relationships were not discussed. It was challenging for the participants to reflect on what they may have benefited from in terms of sexual education. The women were able to speak to the need in the Deaf community for more accessible sexual education and more sexual resources. Suter, McCracken & Calam (2012) surveyed Deaf youth and reported that the participants wanted fewer English written materials, that were often written at reading levels that hindered comprehension and they wanted more interactive and illustrative modes of instruction. Once again, it should be noted, that the participants emphasized the need for more accessible resources for Deaf persons, not explicitly noting the need for LGBTQ Deaf persons, which likely

reflects their deeper integration into the Deaf community and their stronger sense of Deaf identity.

Generational themes may also be present in this group due to their age and the changes within the LGBTQ community as well as the larger society's views of the LGBTQ community. All of the women interviewed indicated that they did not come out as lesbians until later in life, and thus, trying to consider what it would have been like to receive education about lesbian relationships and safe same-sex practices was challenging for them. Thus, the question was reframed to ask what it would have been like to have permission and societal acceptance to explore non-heterosexual feelings, and to have been informed about other types of relationships. Framed this way, the participants agreed that these components were missing from their experiences, by considering how their life might have been impacted.

The third identified theme was the saliency of Deaf identity. Stryker & Burke (2000) state, "Identity salience is defined as the probability that an identity will be invoked across a variety of situations" (p. 286). Saliency can refer to the importance of identity. For example, if asked to define oneself, typically a person begins with their most important or salient variable. It is important to note, that saliency can be affected by context and the larger systemic system as well. Identity is influenced by social roles and structure as well as internal meaning to the individual (Stryker & Burke, 2000). In terms of this research, these women identified "Deaf" as their most salient variable. Influential factors of Deaf identity development include the environment of family, educational experience, the mode of communication used while growing up, and the onset and degree of hearing loss (Chen, 2014). This study did not measure all of these factors, which is a

limitation. McCarn and Fassinger (1996) describe the final phase of identity development as internalization and synthesis, “which entails the woman identifying herself as a member of the minority group, internalizing this identity, and synthesizing it into her overall self-concept. The synthesis is reflected in feelings of fulfillment, security, and the ability to maintain the self-concept across contexts” (p. 523). All of the participants identified “Deaf” as more salient than their sexual orientation identity variable and they were all involved in the Deaf community at various levels. All of the participants described how their deafness was a focal point throughout their childhood and that this continued into adulthood. Stories were shared related to “fixing” deafness, thus teaching the women that deafness was abnormal. Additionally, because of the attention given to their deafness as a consequence of navigating an inaccessible hearing world, they have had to fight for inclusion and even the right to exist just as they are. Being Deaf is a visible identity, once any type of communication begins. Visibility can affect saliency, in that Deaf persons have to fight on a daily basis for their basic needs such as making appointments with doctors. Indeed, the women identified activism for the Deaf community almost as a given; this was not so for the LGBTQ community. Additionally, given the age of these women, they most likely had to fight harder for general accommodations, given that they lived before 1993, when the American With Disabilities Act passed, making it illegal to not provide the needed services for Deaf individuals. More specifically, the women conveyed a greater willingness to participate in Deaf events as compared to LGBTQ events, such as pride parades. It might be that these women simply never had the opportunity to discuss sexual identity with anyone, not even close peers, and thus this identity is not as developed.

This researcher struggled to find identity models that incorporated more than one identity. Singular models fail to incorporate the important aspects of holding multiple identities (Butler, 2012). For example, the deaf identity developmental model incorporates four stages of development including culturally hearing, culturally marginal, immersion, and bicultural (Glickman, 1993). This developmental theory described only speaks to Deaf identity development, not multiple identities. Future research should focus on developing theoretical identity models that can incorporate multiple identity formation so that there is better understanding as to the shifting saliency of identity variables across time and environments, and how intersectionality of identity variables can hinder the development of one or multiple minority identities. In addition, there may generational influences regarding the saliency of identity variables. For example, Vaccaro (2009) conducted a study to compare the differences between Millennials, Baby Boomers and Generation Xers within the LGBQ populations. Results showed, “The most striking actual difference between generations was identity management. Wrestling with multiple, fluid, and intersecting identities was commonplace for Millennials. Even the phrases Millennials used, such as “multiple identities”, “queer moments”, “politically queer”, and “conflicting parts of me” were more complex than the words used by Baby Boomer and Generation Xers used to describe their identity journeys” (p. 131). The research further states that younger generations may be able to help elder LGBQ persons explore their multiple identities. The women in this focus group may not have the language that younger generations do, because of the shift in the larger society to be more open, inclusive and accepting of LGBQ persons.

Limitations

One limitation to this study was the sample size. Only one focus group was conducted, due to challenges accessing this community. The researcher originally intended to create a short video advertising the study, but due to limited resources and time this was not done. Recruitment may have been more successful if recruitment was advertised in American Sign Language versus written English. Immersion into the Deaf community did not occur in the process of completing this project and most definitely hindered access to participants. In the future, efforts to attend Deaf events, and to become integrated into the community in order to gain trust and a working relationship would be essential. Second, there is a need for more Deaf researchers as well, given their access, understanding and involvement within the Deaf community. Another limitation of the study was that the focus group was not a representative sample of the Deaf LGBTQ population. All of the women identified as Caucasian, lesbian and the sample did not represent a range in age. Such lack of representativeness limits the applicability of the results. However, most of the literature historically has focused on the experiences of men, so it is a relative strength that this study represented the unique experiences of women. With regards to age, younger generations of Deaf LGBTQ have likely had different experiences, than their older counterparts, especially related to integration into the LGBTQ community, experiences of discrimination and formal sex education. It may be valuable to work towards obtaining groups that represent generational experiences across time. This could provide opportunity for shared learning, resources and support. Another limitation of this study was that it did not include questions on the experiences of sexism. In addition, the geographic area is also a limitation of the study, in that it is not

representative of the Deaf LGBTQ population and this area has limited LGBTQ and Deaf resources for the community and most likely, a very small LGBTQ Deaf community. Originally, this study was focused on sexual orientation and the Deaf community, but after the focus group was completed, there was a realization that no questions related to gender were asked. It would be helpful in future research to focus on the differences in experiences between men and women, as well as sexual orientation and the Deaf community. Additionally, it would have been beneficial to ask more questions, either on the demographic questionnaire or within the focus group, about the onset of the participants' deafness and what their home life was like growing up, such as did their family communicate with them orally or use American Sign Language, or were they raised by hearing parents or Deaf parents. These questions are important in helping to understand the participants' lived experience.

Clinical Implications

The results from this study indicate that there is a need for culturally aware and inclusive psychological services for the Deaf LGBTQ community. Leblanc and Tully (2001) demonstrated that most Deaf LGBTQ persons never used mental health services in times of distress. Both communities have a history of being medicalized which may affect the rates at which these two populations seek mental health services. They most likely fear discrimination, insensitivity and a general sense of being misunderstood (Ross, Doctor, Dimito, Kuehl & Armstrong, 2007). The women discussed the very real possibility that Deaf persons do not seek treatment due to a lack of fluent American Sign Language therapists in the mental health field. In addition, there was a reticence to seek mental health treatment with an ASL fluent therapist, because of the possibility of

knowing the therapist in other contexts, such as Deaf events. It was clear that the participants preferred an ASL fluent therapist, and not an interpreter. Feelings of vulnerability can hinder disclosure of information with a hearing therapist. This vulnerability is magnified when having to disclose to a therapist with an interpreter present. Clinicians, who are not fluent in ASL, and want to work with this community need to take steps to understand Deaf culture, immerse themselves in this community in order to gain trust, and advertise/provide services in ASL. Allowing clients to choose their own interpreter for sessions would also be beneficial. The participants in the focus group indicated that they would be more likely to engage in services if they were allowed to choose an interpreter they trusted and who would be consistently utilized for all of the sessions. If using an interpreting service, it may be beneficial to evaluate the interpreters' comfort and skill with signing sexually explicit information as well, given the nature of topics that may be discussed with LGBTQ Deaf persons in therapy.

Clinicians can also enhance their success with this population by creating an LGBTQ friendly office space and by examining their own biases and level of awareness relating to sexual orientation. LGBTQ persons still report discrimination when attempting to engage in psychological services (Bowers, Plummer & Minichiello, 2005). This discrimination has shifted from more overt, such as conversion therapies, to subtle microaggressions. For example, Shelton & Delgado-Romero (2013) looked at microaggressions against LGBTQ persons in psychotherapy and found that LGBTQ persons reported microaggressions in the form of over identification efforts, stereotypical presumptions, avoidance of sexual orientation, expressions of heteronormative bias and the idea that sexual orientation is the cause of all presenting issues in therapy. Once

again, these microaggressions can lead to internalized oppression. In addition, “When sexual orientation microaggressions occur, LGBQ clients are forced to internally process the experience, which is ultimately distracting from the therapeutic goals” (p.67).

Clinicians should engage in a process of self-evaluation of their attitudes, skills, and knowledge regarding the LGBQ population and strive towards culturally competent practice. Due to the subtle nature of microaggressions, it is likely that the therapist may unintentionally, express a microaggression in therapy. However, not acknowledging it, nor discussing it, perpetuates further marginalization of the LGBQ client (Shelton & Delgado-Romero, 2013). If this occurs, clinicians should acknowledge the microaggression and express ownership of the impact on the client and the therapeutic relationship. Agreements can then be made to move forward.

Advertisements of specific services, is another means to convey a LGBQ friendly space. For example, indicating in brochures or website, the availability of LGBQ Affirming Therapies, safe space training, flyers with LGBQ information, and artwork that depicts LGBQ symbols can be effective strategies to communicate inclusiveness to the LGBQ community. Inclusive and culturally competence services are needed for this population, and usually have increased benefits (Hicks, 2000). Ross et al. (2007) conducted a study that paired cognitive-behavioral therapy with an anti-oppression framework in a group setting with LGBQ persons to treat depression. Specifically, there were two group sessions devoted exclusively to discussing the LGBQ coming out process and internalized oppression. The results from this study showed a reduced severity of depressive symptoms and an increase in self-esteem among the participants. Even though this study was done with hearing persons, it can be concluded that talking about

oppression, in psychological services is beneficial. Group therapy could be utilized with a hearing facilitator and an American Sign Language interpreter, or ideally with two Deaf facilitators. The group could focus on how issues of internalized oppression regarding sexual orientation and deafness can impact depression and self-worth.

The results also indicate the need for more inclusive formal sexual education related to LGBTQ status. None of the women received information related to different sexual orientations and safe same sex practices. While the women in this group, indicated they had received basic sex education in ASL, they acknowledged that overall, the accessibility of sex education to the Deaf community is limited and further limited for Deaf LGBTQ individuals. This leaves the Deaf LGBTQ population even more vulnerable to sexual abuse, misconceptions about sexual health, safer sex practices and misconceptions about sexual identity formation. Porter & McQuiller Williams (2013), conducted a study on interpersonal violence of LGBTQ Deaf and hard of hearing individuals in a college setting and found that they were more likely to experience sexual, psychological and physical abuse than their heterosexual hearing peers. Given that the LGBTQ Deaf population is more vulnerable to abuse, in all its forms, a preventative strategy should be taken in the form of inclusive sexual education that informs these individuals about interpersonal violence.

Inclusive sexual education would also be beneficial given that all of the participants in this study came out as lesbians later in life and may have experienced less hurdles if they had been given inclusive and adequate sexual identity information. They discussed their hesitancy to tell their family members and others in their community. They discussed that they typically only disclosed their sexual orientation to close family

members and when directly asked. Klinger (2007) found that the more sexual knowledge a person has, the greater the likelihood that the person would disclose their sexual orientation to family members. By providing more inclusive sexual education, individuals are given opportunity to better understand themselves and feel more informed and comfortable with sharing their sexual identity with others. Having support from family is something that is lacking in both the Deaf and LGBTQ community, given that most persons are not born to Deaf parents or to LGBTQ parents. By equipping persons with accurate knowledge power is given to Deaf individuals to make healthy decisions for themselves with regards to their relationships, their sexual practices and in terms of knowing how/when to seek support from family, friends or mental health professionals. Not being able to disclose one's identity to loved ones for fear of rejection or not being understood can cause distress, emotional turmoil and mental health issues.

Further Research

In general, there is a need for further research with LGBTQ Deaf individuals, as it is largely absent from current research. Research recruitment should be done in both written English and American Sign Language. Advertising through any local Deaf services and attending Deaf events, to make oneself visible to the community would also be beneficial. In addition, if the researcher is Deaf, this would enhance a sense of trust and improve accessibility to the community. Further research should include a more accurate representation of the subpopulation in terms of age, race, gender, sexual orientation and religion. Finally, it is paramount that research continues to focus on the intersectionality of identity variables and what this subpopulation feels is needed in terms

of supports and resources. Deaf researchers are needed in order to assure cultural congruency.

Conclusion

The purpose of this study was to gain qualitative information about the lived experiences of Deaf LGBTQ individuals. The results were consistent with the researcher's hypotheses that this subpopulation experiences a lack of inclusive formal sexual education, more reported experiences of discrimination and identification with one community as more salient than the other. The results were also consistent with the limited literature available related to Deaf LGBTQ individuals. Even though the participants did not overtly endorse the feeling of being a "triple minority", the experiences they described covertly represented internalized oppression related to sexual orientation. Butler (2012) discussed when a person holds more than one minority identity, depending on the context, one identity variable make take precedence over the other at any given time. These women may be experiencing a fluidity of identity, but because there is little research pertaining to Deaf persons intersecting identity variables, it is unknown as to why or how Deaf identity became their more salient variable (Nomeland & Nomeland, 2012). One obvious reason could be the availability of a Deaf community with a history of Deaf pride and activism.

The results indicate a need for more inclusive and culturally competent psychological services that take into account and specifically address the experiences of microaggressions, internalized oppression and identity formation of multiple minority identity variables. In addition, there needs to be more Deaf therapists and researchers in

order to better understand and address the unique issues that the LGBTQ Deaf population experiences.

Appendices

Appendix A

Demographic Information:

1. What is your age?
 - a. Under 18
 - b. 18-25
 - c. 25-30
 - d. 30-35
 - e. 35-40
 - f. 40-45
 - g. 45-50
 - h. Older than 50
2. Are you currently enrolled in school?
 - a. If yes, are you enrolled at
 - b. A mainstream school
 - c. A Deaf school
 - d. Home schooled
3. Highest level of education completed?
 - a. Some high school
 - b. GED or high school diploma
 - c. Some college
 - d. Associates degree
 - e. Bachelor's degree
 - f. Graduate school degree
4. What is your gender?
 - a. Female
 - b. Male
 - c. Transgender
 - d. Other
5. What is your sexual orientation
 - a. Heterosexual
 - b. Gay
 - c. Lesbian
 - d. Bisexual
 - e. Pansexual
 - f. Other
6. What is your race/ethnicity?

- a. White/European American
- b. African American
- c. Latino/Latina
- d. Bi-racial
- e. Asian American
- f. Other

Appendix B

LGBQ/Deaf Focus Group Questions:

1. Are you currently “out” as gay/lesbian/bisexual/queer in the Deaf community?
2. What was your “coming out” process like in the Deaf community?
3. What was your “coming out” process like to your family/friends?
4. Who did you first disclose your sexual identity to and why?
5. Have you ever experience discrimination by the Deaf community for being gay/lesbian/bisexual/queer?
6. If yes, please explain
7. Have you ever experienced discrimination by the LGBTQ community because of your Deaf status?
8. If yes, please explain
9. Are you currently active in the Deaf community? If so, how? If not, why?
10. Are you currently active within the LGBTQ community? If so, how? If not, why?
11. Have you ever been involved with any type of mental health services?
12. If yes, please explain your experience including discrimination, difficulty of accessing services and general treatment as an LGBQ/Deaf person.
13. Did you receive formal sex education in school
 - a. If so, what type of school did you attend (mainstream, public, private or school for the deaf)
 - b. Please explain if the sex education provided was relevant and/or inclusive to you as either a member of the LGBQ community or the Deaf community
 - c. How could the sex education provided been better?
14. What other types of questions would you have liked to see on this survey?
15. What did you like and dislike about the survey?
16. Is there anything missing from the survey that you feel should be included?

Appendix C

Consent Form

This consent page is to certify my willingness to participate in this research study.

Amanda Lynn Schaad, a doctoral student in the School of Professional Psychology at Wright State University in Dayton, OH, is conducting a research study to help understand the experiences of those who identify as Deaf and Lesbian, Gay, Bisexual, Transgender or Queer (LGBTQ). I am being asked to participate in this study because I identify as both Deaf and LGBTQ.

My participation in this study will involve participating in a focus group with others who identify as I do, or in an individual interview. I will be asked to answer several questions about my experiences in both the Deaf community and LGTBQ community. Interpretation services will be provided by a fluent American Sign Language interpreter. My answers will be spoken out loud by the interpreter and recorded onto a tape recorder. I will also be asked some questions about my demographics, such as my age and race. This information will not be used in any way to identify me personally. Information that I provide will be kept strictly confidential and any responses I provide will not be associated with my identity in any way. Other members of the group will be asked to keep all conversation from the focus group confidential. Participation in the focus will last approximately 2 hours.

It is possible that my participation in this study may elicit mild psychological distress related to the disclosure of information of a personal and potentially difficult nature. If I experience psychological distress that is intolerable or beyond what I expect, I may choose to contact a mental health professional to address my concerns by asking my primary care physician for a referral. Also you may contact Consumer Advocacy Model (CAM) by telephone or TTY at 937-222-2400. CAM is located at 6 South Patterson Blvd. Dayton, Ohio 45402. Ellis Human Development Institute also offers mental health services which is located at 9 Edwin C Moses Blvd Dayton, OH 45402. They can be reached at 937-775-4300.

There will be no direct benefit to me from participating in this study. However, the information that I provide may help health professionals better understand the experiences of Deaf and LGBTQ persons

Any information about me obtained from this study will be kept strictly confidential and I will not be identified in any report or publication. PARTICIPATION IN THIS RESEARCH IS VOLUNTARY. I am free to decline to be in this study, or to withdraw from it at any point.

If I have questions about this research study, I can contact the researcher, Amanda Lynn Schaad, at 330-317-5776 or schaad.3@wright.edu or Dr. Julie Williams, faculty advisor, at 937-775-3407 or julie.williams@wright.edu. If I have general questions about giving

consent or my rights as a research participant in this research study, I can call the Wright State University Institutional Review Board at 937-775-4462 or email them robyn.wilkes@wright.edu. If I would like a copy of the group (not individual) results of this study, I can contact Amanda Lynn Schaad, at the phone number or e-mail address provided above. These results will be available by June 2016.

I have read and understand the above information. By participating in the focus group interview I am indicating my consent to participate in this study.

Appendix D

Flyer



Figure 1D: Sign language spelling for LGBTQ

Do you identify as Deaf?

Do you also identify as LGBTQ?

If so, please consider participating in the following research study:

Amanda Lynn Schaad, a doctoral student in the School of Professional Psychology at Wright State University in Dayton, OH, is conducting a pilot research study that will investigate the experiences of those who identify as Deaf and Lesbian, Gay, Bisexual, Transgender or Queer (LGBTQ). Specifically, the purpose of this research is to explore the lived experiences of inclusion and exclusion around LGBTQ identification. This information will be used to inform future research and mental health providers. This research is being conducted under the supervision and advisement of Dr. Julie Williams, faculty advisor.

The study will be conducted in the form of focus groups, in which participants will meet together and discuss their experiences as Deaf, LGBTQ persons. Additional questions will be asked about demographics and experiences. Focus groups will be conducted by the researcher and a fluent American Sign Language co-facilitator.

If you are willing to participate, please email the researcher at schaad.3@wright.edu to indicate interest in this study. Focus group times and places will be determined with each group.

For further information about this research study, you may contact Amanda Lynn Schaad, at or schaad.3@wright.edu or Dr. Julie Williams, faculty advisor, at julie.williams@wright.edu.

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